



REPORT ON THE FATALITY OF:

Jeniyah Harris-Holmes

Date of Birth: 12/14/2011

Date of Death: 2/24/2012

Date of Oral Report: 2/24/2012

**FAMILY NOT KNOWN TO ANY PRIVATE OR PUBLIC CHILD
WELFARE AGENCY**

**REPORT FINALIZED ON:
April 18, 2013**

This report is confidential under the provisions of the Child Protective Services Law and cannot be released.

(23 Pa. C.S. Section 6340)

Unauthorized release is prohibited under penalty of law.

(23 Pa. C.S. 6349 (b))

Reason for Review:

Senate Bill 1147, Printer's Number 2159 was signed into law on July 3, 2008. The bill became effective on December 30, 2008 and is known as Act 33 of 2008. As part of Act 33 of 2008, DPW must conduct a review and provide a written report of all cases of suspected child abuse that result in a child fatality or near fatality. This written report must be completed as soon as possible but no later than six months after the date the report was registered with Child Line for investigation.

Act 33 of 2008 also requires that county children and youth agencies convene a review when a report of child abuse involving a child fatality or near fatality is indicated or when a status determination has not been made regarding the report within 30 days of the oral report to Child Line. Philadelphia County was not required to convene a review team in accordance with Act 33 of 2008 related to this report. The case was [REDACTED] within 30 days.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
Jeniyah Harris-Holmes	victim child	12/14/2011
[REDACTED]	Mother	[REDACTED]/1991
[REDACTED]	HHM (male)	[REDACTED]/1976
[REDACTED]	Maternal Cousin	[REDACTED]/1993
[REDACTED]	Bio-Father of Victim child	[REDACTED]/1989
[REDACTED]	HHM	[REDACTED]/1971
[REDACTED]	MGM (non-household member)	[REDACTED]/1969

Notification of Child Fatality:

On 02/24/2012, [REDACTED] contacted ChildLine to report that victim child was dead on arrival at St. Christopher Hospital. According [REDACTED] the [REDACTED] reports the biological mother last fed her child at 3:00 am. The [REDACTED] stated that she woke up at 5am and heard the mother screaming that the baby was not breathing. The [REDACTED] tried CPR and called 911. EMS arrived and continued CPR until they arrived at the hospital.

Summary of DPW Child Fatality Review Activities:

The Southeast Regional Office of Children, Youth and Families obtained and reviewed all current case records from DHS pertaining to the family.

Summary of Services to Family:

Children and Youth Involvement prior to Incident:

The family had no DHS involvement prior to this report.

Circumstances of Child Fatality and Related Case Activity:

On February 24th, 2012, the [REDACTED] ChildLine to report that Jeniyah Holmes was dead on arrival, as reported by the St. Christopher's Hospital for Children. When the attending physician pronounced the child dead, it was determined that the child's cause of death was Cardiac Arrest, Sudden Infant Death Syndrome (SIDS).

According to the referral, the [REDACTED] reports the biological mother last fed her child at 3:00am on 02/24/2012 and then put her in the infant swing at 3:30 am. The [REDACTED] states that she woke up at 5 am and heard the mother screaming that the baby was not breathing. The [REDACTED] tried CPR and called 911. EMS arrived and continued CPR. The child was deceased when she arrived at the hospital. Upon exam, the child had no bruising. A skeletal survey was done. Mother was appropriately distraught. The baby was pronounced dead by Dr [REDACTED] at 5:39am at St. Christopher's Hospital.

O 03/06/2012, a DHS Supervisory conference was held on [REDACTED] determination. The report was deemed [REDACTED] The [REDACTED] investigation did not reveal adequate evidence to support the allegations. St. Christopher's determined that the child did not have any internal or external injuries. St. Christopher's documented the cause of death as SIDS. The Medical Examiner's Office did not find that the child had any injuries. Mother did not have any other children in the home.

The investigation was completed on 03/06/2012 [REDACTED]
[REDACTED]

Current Case Status:

On 03/05/2012, the social worker completed her closing visit with mother. Mother does not have any other children. Mother is reported to have a [REDACTED] [REDACTED] The social worker completed a [REDACTED] follow up. The follow up revealed that mother [REDACTED] many times in the past couple of years, the last time being prior to her pregnancy with the victim child. The social worker provided mother with resources for support groups, [REDACTED] [REDACTED], Crisis Response Center (CRC) and Women against Abuse. Presently there is no criminal case.

County Strengths, Deficiencies and Recommendations for Change as Identified by the County's Child Fatality Report:

Philadelphia County did not convene a review team in accordance with Act 33 of 2008 related to this report because the report [REDACTED] within 30 days.

Department Review of County Internal Report:

The County was not required to complete a report under Act 33.

Department of Public Welfare Findings:

County Strengths:

The investigation was completed within 30 days of the ChildLine report. The county obtained the medical reports to assist in their determination of the investigation.

County Weaknesses:

There are none noted

Statutory and Regulatory Areas of Non-Compliance:

There are none noted

Department of Public Welfare Recommendations:

There are no recommendations as a result of this review.